

MDR Tracking Number: M5-04-1463-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-23-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The therapeutic group exercises and office visits from 1-29-03 through 8-18-03 **were found** to be medically necessary. The neuromuscular re-education, massage therapy, gait training, joint mobilization, therapeutic activities and therapeutic exercises from 1-29-03 through 8-18-03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 4-5-04 the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Regarding CPT code 97112 for dates of service 8-26-03, 8-27-03, 9-3-03, 9-4-03, 9-9-03, 9-10-03, 9-12-03, 9-16-03, 9-18-03, 9-19-03, 9-22-03, 9-24-03, 9-26-03 and 9-30-03: These services were billed by the requestor and denied by the carrier. Neither party submitted EOB's for these dates of services (and did not timely respond to the request for additional information). Therefore, these dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$467.74.**

Regarding CPT code 97116 for dates of service 8-26-03, 8-27-03, 9-3-03, 9-4-03, 9-9-03, 9-10-03, 9-12-03, 9-16-03, 9-18-03, 9-19-03, 9-22-03, 9-24-03, 9-26-03 and 9-30-03: These services were billed by the requestor and denied by the carrier. Neither party

submitted EOB's for these dates of services (and did not timely respond to the request for additional information). Therefore, these dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$402.64.**

Regarding CPT code 97150 for dates of service 8-26-03, 8-27-03, 9-3-03, 9-4-03, 9-9-03, 9-10-03, 9-12-03, 9-16-03, 9-18-03, 9-19-03, 9-22-03, 9-24-03, 9-26-03 and 9-30-03: These services were billed by the requestor and denied by the carrier. Neither party submitted EOB's for these dates of services (and did not timely respond to the request for additional information). Therefore, these dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$1389.70.**

Regarding CPT code 97124 for date of service 9-26-03: These services were billed by the requestor and denied by the carrier. Neither party submitted EOB's for these dates of services (and did not timely respond to the request for additional information). Therefore, these dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$25.70.**

Regarding CPT code 99213 for date of service 9-12-03: These services were billed by the requestor and denied by the carrier. Neither party submitted EOB's for these dates of services (and did not timely respond to the request for additional information). Therefore, these dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$59.00.**

Regarding CPT code 99212 for date of service 10-2-03: These services were billed by the requestor and denied by the carrier. Neither party submitted EOB's for these dates of services (and did not timely respond to the request for additional information). Therefore, these dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$41.91.**

This Finding and Decision is hereby issued this 3rd day of November 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division
DA/da

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202(c); plus all accrued interest due at the time of payment to the requestor

within 20 days of receipt of this order. This Decision is applicable for dates of service 8-26-03 through 10-2-03 in this dispute

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 3rd day of November 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

March 30, 2004
Amended October 13, 2004.

Roy Lewis
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-04-1463-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient was working in a restaurant when she slipped and fell on a floor that was covered in grease. She had an immediate onset of low back, head and neck pain. She was seen at the ____ and was prescribed Lortab for the pain. She eventually sought treatment from the ____ and was diagnosed with a lumbar sprain/strain, fracture of the coccyx and cervical radiculitis. MRI of the lumbar spine demonstrated a L5 discopathy, but not a herniation. A needle EMG confirmed a radiculopathy at the level of S1. She was recommended to have a series of ESI treatments, but that therapy was disapproved according to the records. Apparently a second request for ESI therapy was made and it was approved. Records from the office of Dr. H indicate that the ESI therapy was not successful on the first try. She underwent pain management consultations with Dr. K and he discontinued Flexeril and Neurotin and prescribed Xanax and Vicodin. In numerous entries of the records, the patient reported extraordinarily high levels of pain. A 9/10 on the VAS was noted in the records of Dr. H. She was treated with conservative care by Dr. A to include manipulations and passive/active care.

DISPUTED SERVICES

The carrier has denied the medical necessity of neuromuscular re-education, massage therapy, gait training, therapeutic group exercises, joint mobilization, office visits, therapeutic activities and therapeutic exercises from July 29, 2003 through August 18, 2003.

DECISION

The reviewer disagrees with the prior adverse determination for therapeutic group exercises and office visits.

The reviewer agrees with the prior adverse determination for all other services.

BASIS FOR THE DECISION

There was reasonable documentation to indicate that the services rendered by the treating provider were necessary on this case. Specifically, this patient had serious pain in the lumbar that was well documented by numerous providers, including a designated doctor and was in need of activities that could improved functional capacity. The therapeutic group activities and office visits do fit well within the categories of therapies that would address the deficits of this patient.

Unfortunately, the remaining therapies were not documented for medical necessity. No records could be found which could validate and justify the use of such extensive passive therapies on this patient. There was no indication that one-on-one therapy was ever indicated in this patient, despite the pain level. As a result, the remainder of the therapy cannot be validated for its medical necessity.

____ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ____ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,